Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 264-6819
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
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NECESSITY OF TREATMENT
DISPUTE RESOLUTION REQUEST

Direct all inquiries to: Medical Cost Dispute Unit and mail to the address above or telephone (608) 264-6819.

INSTRUCTIONS: Complete Section 1 **or** Section 2 **and all** sections (3, 4 & 5) on the reverse side.

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits.

Personal information you provide may be used for secondary purposes [(Privacy Law, s. 15.04(1)(m)].

SECTION 1. REQUEST FOR INDEPENDENT REVIEW

On (mo/day/yr) _____, I received notice within 60 days of submitting the bill for payment from the insurer or self-insurer (listed in Section 3) refusing to pay for treatment (specified in Section 4) because it was not necessary. The notice also informed me of the items I have checked below:

☐ 1. The reason that the insurer or self-insurer believes the treatment was unnecessary.

☐ 2. The organization and credentials of any person who provided supporting documentation to the insurer or self-insurer.

☐ 3. My right to submit this dispute to the Worker's Compensation Division within 9 months from the date (above) on which I received the notice denying payment.

☐ 4. My obligation to provide the insurer or self-insurer at least 30 days prior to submitting this dispute to the division a written explanation stating why the treatment was reasonably required to cure and relieve the effects of the injury.

On (mo/day/yr) _____, I provided the insurer a written explanation mailed to the address which the insurer or self-insurer directed me to use regarding this dispute.

☐ 5. I may not collect the disputed fee from the employee-patient once I receive notice from the insurer or self-insurer that the treatment was in dispute, per 102.16(2m)(b), Stats.

☐ 6. The division will charge either the insurer or me for their cost of obtaining an independent, impartial, expert medical opinion on the necessity of treatment; if this is the first necessity of treatment dispute resolution request I have submitted to the division for treatment provided on or after January 1, 1992; the insurer will pay the full cost; but in all subsequent disputes which I file, the losing party will pay the full cost of obtaining the expert's opinion.

This is the first dispute I have submitted to the division regarding the necessity of treatment provided on or after January 1, 1992. ☐ Yes ☐ No

SECTION 2. REQUEST FOR DEFAULT ORDER: LATE NOTICE - OVER 60 DAYS

(May be requested only if review is **not** requested in Section 1 above.

On (mo/day/yr) _____, I submitted my bill for treatment to the insurer or self-insurer (listed in SECTION 3).

I certify that:

☐ I was not notified within 60 days that liability or extent of liability is in dispute.

☐ the insurer or self-insurer failed to pay the bill or to provide me with notice within 60 days of the date I submitted my initial bill explaining the reason why the treatment was not necessary.

SECTION 3.	NAME	ADDRESS
Individual Health Care Practitioner		
Insurer or Self-Insurer		
Employer (at time of injury)		
Employee – Patient		
Injury Date	Social Security Number	

Are you continuing to treat this patient for the injury? ☐ **Yes** ☐ **No**

SECTION 4.	DATES		AMOUNT		
SPECIFIC TREATMENT IN DISPUTE	FROM	TO	CHARGED	PAID	DISPUTED
		TOTALS			

SECTION 5. As required by law, I am enclosing copies of all correspondence and medical records relating to this dispute including:

1. The insurer's or self-insurer's initial notice refusing to pay (if any). ☐ Yes ☐ No
2. My written response explaining to the insurer why the treatment was necessary (if any). ☐ Yes ☐ No

As required by law, I am sending one copy of this dispute resolution request with all attachments to the insurer or self-insurer at the time I filed this request with the Division. ☐ Yes ☐ No

<u>Individual</u> health care <u>practitioner</u> (this must be a physician, chiropractor, psychologist, dentist, physician assistants, advanced practice nurse prescriber, or podiatrist.) whose treatment or order of treatment is the subject of this dispute per DWD. 80.73(2)(d) Wisc. Admin. Code.

Practitioner Name (print or type)	License Number to Practice in WI	Telephone Number ( )

Practitioner Signature: _____ **Date Signed:** _____